

<i>SERFF Tracking Number:</i>	<i>AMGN-126131166</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>The United States Life Insurance Company in the State</i>	<i>Tracking Number:</i>	<i>42233</i>
	<i>City of New York</i>		
<i>Company Tracking Number:</i>	<i>G-19550</i>		
<i>TOI:</i>	<i>H11G Group Health - Disability Income</i>	<i>Sub-TOI:</i>	<i>H11G.005 Combined Short Term and Long Term</i>
<i>Product Name:</i>	<i>Group Life/ Disability</i>		
<i>Project Name/Number:</i>	<i>Member Upgrade Application/G-19550</i>		

Filing at a Glance

Company: The United States Life Insurance Company in the City of New York

Product Name: Group Life/ Disability SERFF Tr Num: AMGN-126131166 State: ArkansasLH

TOI: H11G Group Health - Disability Income SERFF Status: Closed State Tr Num: 42233

Sub-TOI: H11G.005 Combined Short Term and Co Tr Num: G-19550 State Status: Approved-Closed
Long Term

Filing Type: Form Co Status: Reviewer(s): Rosalind Minor

Author: Maggie Sheehan Disposition Date: 05/01/2009

Date Submitted: 04/28/2009 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval Implementation Date:

State Filing Description:

General Information

Project Name: Member Upgrade Application

Project Number: G-19550

Requested Filing Mode:

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 05/01/2009

Deemer Date:

Filing Description:

The United States Life Insurance Company in the City of New York (USL) wishes to submit the above referenced filing for your review and approval.

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Group Market Type: Employer, Association

Explanation for Other Group Market Type:

State Status Changed: 05/01/2009

Corresponding Filing Tracking Number:

The individual application, G-19550 will be used to increase insurance amounts on any underwritten product (DI, EMM and Life) based on the health status being unchanged from the original application for coverage. This individual

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<i>Product Name:</i>	<i>Group Life/ Disability</i>		
<i>Project Name/Number:</i>	<i>Member Upgrade Application/G-19550</i>		

application is a new form and is not intended to replace any existing forms previously filed and approved.

Any bracketed information is being filed as variable and is illustrative. An Explanation of Variability is enclosed. Unless otherwise informed, we reserve the right on a case by case basis to alter the layout of the enclosed form, including color, type face and font, and to go outside the range of variables set forth in the application if we are requested to do so by the policyholder, but will only do so if such changes are within the allowable parameters or requirements in the state statutes.

We certify that the type size will always remain as the state required size and all statutory/regulatory requirements will not be changed. For example, the logo in the upper right hand corner of the application will be the logo of the association or company utilizing the application who will then determine the address of the administrative office.

This application will be implemented for use upon approval by your Department.

Your review of this filing is appreciated. Please contact me if you have any questions.

Company and Contact

Filing Contact Information

Maggie Sheehan, Analyst	maggie_sheehan@aigag.com
3600 Route 66	(732) 922-7688 [Phone]
Neptune, NJ 07754	(732) 922-5593[FAX]

Filing Company Information

The United States Life Insurance Company in the City of New York	CoCode: 70106	State of Domicile: New York
830 Third Avenue	Group Code: 12	Company Type:
7th Floor		
New York, NY 10022	Group Name: AIG	State ID Number:
(713) 831-3508 ext. [Phone]	FEIN Number: 13-5459480	

SERFF Tracking Number: AMGN-126131166 State: Arkansas

Filing Company: The United States Life Insurance Company in the State Tracking Number: 42233
City of New York

Company Tracking Number: G-19550

TOI: H11G Group Health - Disability Income Sub-TOI: H11G.005 Combined Short Term and Long Term

Product Name: Group Life/ Disability

Project Name/Number: Member Upgrade Application/G-19550

Filing Fees

Fee Required? Yes

Fee Amount: \$20.00

Retaliatory? No

Fee Explanation:

Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The United States Life Insurance Company in the City of New York	\$20.00	04/28/2009	27475182

SERFF Tracking Number:	AMGN-126131166	State:	Arkansas
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	City of New York		
Company Tracking Number:	G-19550		
TOI:	H11G Group Health - Disability Income	Sub-TOI:	H11G.005 Combined Short Term and Long Term
Product Name:	Group Life/ Disability		
Project Name/Number:	Member Upgrade Application/G-19550		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	05/01/2009	05/01/2009

SERFF Tracking Number:	AMGN-126131166	State:	Arkansas
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	City of New York		
Company Tracking Number:	G-19550		
TOI:	H11G Group Health - Disability Income	Sub-TOI:	H11G.005 Combined Short Term and Long Term
Product Name:	Group Life/ Disability		
Project Name/Number:	Member Upgrade Application/G-19550		

Disposition

Disposition Date: 05/01/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: AMGN-126131166 State: Arkansas

Filing Company: The United States Life Insurance Company in the State Tracking Number: 42233
City of New York

Company Tracking Number: G-19550

TOI: H11G Group Health - Disability Income Sub-TOI: H11G.005 Combined Short Term and Long Term

Product Name: Group Life/ Disability

Project Name/Number: Member Upgrade Application/G-19550

Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Explanation of Variability	Approved-Closed	Yes
Form	Member's Upgrade Application	Approved-Closed	Yes

SERFF Tracking Number: AMGN-126131166 State: Arkansas

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City of New York

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TOI: H11G Group Health - Disability Income Sub-TOI: H11G.005 Combined Short Term and Long Term

Product Name: Group Life/ Disability

Project Name/Number: Member Upgrade Application/G-19550

Form Schedule

Lead Form Number: G-19550

Review Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	G-19550	Application/Member's Upgrade Enrollment Application Form	Initial			USL Generic Upgrade App _Final_.pdf

The United States Life Insurance Company in the City of New York

[MEMBER’S UPGRADE]1 APPLICATION FOR
[TERM LIFE] 14 INSURANCE

[Home Office: [830 Third Avenue, New York, New York 10022-6565]2
(Herein called the Company)

[Administrative Office: 3600 Route 66, Medical Underwriting 3-L, P.O. Box 1588 Neptune, NJ 07754-1588]3

[ASSOCIATION LOGO]4

[Sponsoring Association Name]5

<p>[Please respond by:] [Date]6</p> <p>[<input type="checkbox"/> YES I'd like to add \$ [X] to my current coverage]19</p> <p>[Member's Name: [Please circle one: [Mr./Mrs./Ms./Miss]</p> <div><div></div><div>First</div><div>Middle</div><div>Last</div></div> <p>]7</p> <p>[Address:</p> <div><div></div><div>Street</div></div> <p>]8</p> <div><div></div><div>City</div><div>State</div><div>Zip</div></div> <p>[Address2:</p> <div><div></div><div>Street</div></div> <p>]8</p> <div><div></div><div>City</div><div>State</div><div>Zip</div></div> <p>[Spouse of Member's Name:</p> <div><div></div><div>First</div><div>Middle</div><div>Last</div></div> <p>]20</p> <p>[Questions? 1-800-229-0451 Call us Monday through Friday between 8:00 a.m. and 5:00 p.m. EST. (T.D.D. 1-203-754-4410)]9</p> <p>[Please be sure to:</p> <div><div>1.</div><div>Date and Sign this form.</div></div> <div><div>2.</div><div>Mail the form together with your premium in the enclosed postage paid envelope.] 15</div></div>	<p>Upgrade Insurance Amount : [_____] 10</p> <p>Premium Due: [_____] 11</p> <p>[Billing Options- Please check one:</p> <div><div>Checking Account: Account # _____ Routing # : _____</div><div>Credit Card: Type _____ Account # _____ Exp Date.: _____</div></div> <p>[Cardholder Name: _____]</p> <p>Pension Deduction EFT Payroll Deduction (Available in locales that made necessary arrangements for this option) Semi-Annual Direct Bill Other Account Deduction: Type _____ Account No. _____ Expiration Date. : _____] 12</p> <p>[Bill Me:</p> <div><div>Monthly</div><div><input type="checkbox"/> Semi-Annually</div></div> <div><div>Quarterly</div><div><input type="checkbox"/> Annually] 13</div></div> <p>[Mail this form to: [Administrator Name] [address]] 16</p>
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I understand that this insurance is approved based on the answers provided on my [term life] 14 application, a copy of which is attached. I attest that there has been no change in my health status and that I have not consulted any physician or medical practitioner since the completion of the attached application. (List any exception below, sign and date)

[Important Notice: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which may be a crime. (This notice does not apply in Virginia.) (For state specific variations(s) refer to page [xx] of this application.).]17

[☐ Authorization for Credit Card Charge or Electronic Funds Transfer

I request and authorize withdrawals or charges against my account based on my selected payment method specified above, and such financial institution to process these withdrawals/charges as if I had signed them, for the purpose of collecting premium contributions due for the coverage listed above. I understand that by completing the required information regarding my enrollment I am authorizing automatic deductions/charges for the insurance premium from my account.

The premium, based on the plan I selected, will be deducted from or charged to my account as indicated above unless I call the plan administrator to cancel. I understand that I must contact the plan administrator if I wish to cancel these automatic deductions/charges or if I wish to cancel my insurance coverage.

I also understand that my authorization for the deduction is not part of my certificate of insurance, nor does it modify any terms or conditions contained therein. The insurance company is not liable if the financial institution dishonors any amount deducted/charged and may terminate my insurance coverage immediately if premium for my insurance is not paid. Payment of the initial premium is one of the conditions required in order for my coverage to be placed in effect. I understand that if the deduction/charge is declined for any reason, my coverage will not take effect.

☐I authorize payments to be automatically deducted from my paycheck.

☐ I hereby request to be direct billed by mail for this coverage.]18

A copy of this application will be attached to and made a part of your certificate.

Date _____ Member/Applicant’s Signature _____

The United States Life Insurance Company in the City of New York

[Important Notice

For residents of Arkansas, Louisiana, Maryland and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For residents of Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

For residents of the District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

For residents of Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

For residents of Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

For residents of Maine, Tennessee and Washington:

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

For residents of New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

For residents of New Mexico: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

For residents of New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

For residents of Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

For residents of Oklahoma: Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

For residents of Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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<i>Product Name:</i>	<i>Group Life/ Disability</i>		
<i>Project Name/Number:</i>	<i>Member Upgrade Application/G-19550</i>		

Rate Information

Rate data does NOT apply to filing.

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Product Name: Group Life/ Disability
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Supporting Document Schedules

Satisfied -Name: Flesch Certification	Review Status: Approved-Closed	05/01/2009
Comments:		
Attachments:		
AR LH214AR_112805.pdf		
Final Readability Certification _KC_.pdf		
Satisfied -Name: Application	Review Status: Approved-Closed	05/01/2009
Comments:		
Attachment:		
USL Generic Upgrade App _Final_.pdf		
Satisfied -Name: Explanation of Variability	Review Status: Approved-Closed	05/01/2009
Comments:		
Attachment:		
USL Generic Upgrade Application EOVS_Final_.pdf		

Certificate of Compliance with Arkansas Rule and Regulation 19

Insurer: The United States Life Insurance Company in the City of New York

Form Number(s): G-19550

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.



Signature of Company Officer

Keith Coleman

Name

Assistant Secretary

Title

4/28/2009

Date

READABILITY CERTIFICATION

I, Keith Coleman, Assistant Secretary, do hereby certify that the enclosed form has been tested and meets the minimum reading score.

The Flesch Score is as follows:

Member's Upgrade Application For Term Life Insurance G-19550 40.4

A handwritten signature in black ink that reads "Keith W. Coleman". The signature is written in a cursive style with a horizontal line extending from the end of the name.

Date: 4/28/2009

Keith Coleman
Assistant Secretary

The United States Life Insurance Company in the City of New York

[MEMBER’S UPGRADE]1 APPLICATION FOR
[TERM LIFE] 14 INSURANCE

[Home Office: [830 Third Avenue, New York, New York 10022-6565]2
(Herein called the Company)

[Administrative Office: 3600 Route 66, Medical Underwriting 3-L, P.O. Box 1588 Neptune, NJ 07754-1588]3

[ASSOCIATION LOGO]4

[Sponsoring Association Name]5

<p>[Please respond by:] [Date]6</p> <p>[<input type="checkbox"/> YES I'd like to add \$ [X] to my current coverage]19</p> <p>[Member's Name: [Please circle one: [Mr./Mrs./Ms./Miss]</p> <div><div></div><div>First</div><div>Middle</div><div>Last</div></div> <p>[Address:</p> <div><div></div><div>Street</div></div> <div><div></div><div>City</div><div>State</div><div>Zip</div></div> <p>[Address2:</p> <div><div></div><div>Street</div></div> <div><div></div><div>City</div><div>State</div><div>Zip</div></div> <p>[Spouse of Member's Name:</p> <div><div></div><div>First</div><div>Middle</div><div>Last</div></div> <p>[Questions? 1-800-229-0451 Call us Monday through Friday between 8:00 a.m. and 5:00 p.m. EST. (T.D.D. 1-203-754-4410)]9</p> <p>[Please be sure to:</p> <div><div>1.</div><div>Date and Sign this form.</div></div> <div><div>2.</div><div>Mail the form together with your premium in the enclosed postage paid envelope.] 15</div></div>	<p>Upgrade Insurance Amount : [_____] 10</p> <p>Premium Due: [_____] 11</p> <p>[Billing Options- Please check one:</p> <div><div>Checking Account: Account # _____ Routing # : _____</div><div>Credit Card: Type _____ Account # _____ Exp Date.: _____</div></div> <p>[Cardholder Name: _____]</p> <p>Pension Deduction EFT Payroll Deduction (Available in locales that made necessary arrangements for this option) Semi-Annual Direct Bill Other Account Deduction: Type _____ Account No. _____ Expiration Date. : _____] 12</p> <p>[Bill Me:</p> <div><div>Monthly</div><div><input type="checkbox"/> Semi-Annually</div></div> <div><div>Quarterly</div><div><input type="checkbox"/> Annually] 13</div></div> <p>[Mail this form to: [Administrator Name] [address]] 16</p>
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I also understand that my authorization for the deduction is not part of my certificate of insurance, nor does it modify any terms or conditions contained therein. The insurance company is not liable if the financial institution dishonors any amount deducted/charged and may terminate my insurance coverage immediately if premium for my insurance is not paid. Payment of the initial premium is one of the conditions required in order for my coverage to be placed in effect. I understand that if the deduction/charge is declined for any reason, my coverage will not take effect.

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For residents of Pennsylvania: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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[MEMBER'S UPGRADE] APPLICATION FOR [TERM LIFE] INSURANCE

Explanation of Variability for Form No. G-19550

GENERAL COMMENTS

- Any bracketed or handwritten information is being filed as variable. This data will vary from case to case. Variable data will never exclude or limit provisions required by the jurisdiction in which the group policy is issued. The appropriate required language will always appear, but the arrangement or formatting may vary. Since the use of the enrollment may vary from electronic, to face-to-face, to direct mail, to telemarketing, etc... we need flexibility to conform the layout of the items found in the application to the layout in the marketing materials, etc... We certify that the type size will always remain as the State required size and all statutory/regulatory provisions and requirements will not be changed.
- Brackets around numbers or alphas in a listing and punctuation or words such as, "and"/"or" in a listing will be included or deleted as needed in order to make the statement read correctly. Numeric variables within the application will reflect the policy provisions and will always comply with the minimum statutory requirements of the jurisdiction in which the group policy is issued.
- The format may vary; however, the relative prominence of the provisions will not change.
- The Association, Administrator or Plan Logo, if inserted, will vary on a case-by-case basis.

Please note: The above variables will not be explained everywhere they appear. Items which are considered illustrative are not explained.

SECTION	EXPLANATION OF VARIABLE AREA
1. Application Name	The reference to the type of application may vary. The term upgrade may be referred to as a different marketing name; the term member may be included or omitted or may vary.
2. and 3. Addresses	This information will be included as shown or omitted. This may also be revised to reflect the appropriate address based upon client needs.
4. Logo	A space has been left for Association, Administrator or Plan logos to be included if a particular client requests it. Formatting of this information and some content may also vary depending upon group and solicitation method.
5. Association Name	A space has been left for the Association name to be included if a particular client requests it.

[MEMBER'S UPGRADE] APPLICATION FOR [TERM LIFE] INSURANCE

Explanation of Variability for Form No. G-19550

- 6. Date** The respond date will either appear as shown or be omitted.
- Date will vary based upon solicitation date and will be prefilled on the form.
- 7. and 8. Customer Name address** The customer information (name and address) will appear as shown and may be prefilled as part of the solicitation.
- Formatting of this information and some content may also vary depending upon group and solicitation method.
- In certain instances Member Name may be replaced by any of the following terms:
Applicant Name
Spouse of Member's Name
Enrollee Name
Individual Name
Applicant + 1 Name
Customers
Alumni
Clients
Participants
- We have also included a section of the prefix to be included before the name or omitted.
- 9. Questions** This section may appear as shown or be omitted.
- Formatting of this information and some content may also vary depending upon client.
- The phone numbers will vary based upon group contact information.
- 10. Upgrade Amount** This information may appear as shown or may be omitted.
- The amount offered will vary based upon client and offering.
- Upgrade amounts may be pre-filled or spaces may be left for applicant to choose a benefit amount.
- Other descriptive information regarding the upgrade amount may be included as shown or omitted.

**[MEMBER'S UPGRADE] APPLICATION FOR
[TERM LIFE] INSURANCE**

Explanation of Variability for Form No. G-19550

- | | |
|------------------------------------|---|
| 11. Premium | <p>This information may appear as shown or may be omitted.</p> <p>Other descriptive information regarding premium due may be included as shown or omitted.</p> |
| 12. Billing Options | <p>The options listed will be included as shown or one, some or all of the options available may be omitted.</p> |
| 13. Billing Modes | <p>The billing mode options listed will be included as shown or one, some or all of the options available may be omitted</p> |
| 14. Insurance Name | <p>The reference to the name of the insurance coverage may vary.
This application may be to increase the amount of any life or A&H coverages inforce at the option of the client.</p> |
| 15.-16. Instructions | <p>The Instructional information may appear as shown or some or all may be omitted.</p> <p>Content may vary based upon the needs of the client.</p> |
| 17. Important Notice | <p>The language will be included as shown, or may be replaced with the appropriate state specific language.</p> |
| 18. EFT/Credit Card Consent | <p>This section may be included as shown or omitted.</p> <p>In some instances the following wording may replace the wording as currently shown:</p> <p>By signing the application, the credit union is authorized to disclose account number to the administrator in order to make monthly premium deductions from credit union account for the coverage selected above. This authority is to remain in effect until cancelled by written notice to the Plan Administrator.</p> |

**[MEMBER'S UPGRADE] APPLICATION FOR
[TERM LIFE] INSURANCE**

Explanation of Variability for Form No. G-19550

- 19. Consent to Upgrade** The consent to upgrade will either appear as shown or be omitted at the option of the client.
- Format of this section and amounts will vary based upon solicitation and client options.
- 20. Spouse of Member** This section will either appear as shown or be omitted.